

## DEHYDRATION PROTOCOL

Name \_\_\_\_\_

The following is intended as guideline. This protocol does not supersede facility policy, nursing judgment, or physician orders.

### Call 911

- If the person appears gravely ill or you are concerned about their immediate health and safety
- If the person is dizzy
- If the person is lightheaded
- If the person is lethargic or listless
- If the person is confused or delirious
- Other (specific to the person): \_\_\_\_\_  
\_\_\_\_\_

### Signs and Symptoms of Dehydration

- |  |  |
|--|--|
| <ul style="list-style-type: none"><li>• Dry Sticky Mouth</li><li>• Low or no urine output</li><li>• Lack of tears</li><li>• Sunken eyes</li><li>• Strong, Odorous &amp;/or Dark Urine</li><li>• Lethargic-Very sleepy</li><li>• Elevated temperature</li><li>• Rapid weight loss</li><li>• Dry skin, dry cracked lips</li><li>• Thirst</li></ul> | <ul style="list-style-type: none"><li>• Headache</li><li>• Lack of sweating</li><li>• Dizziness/light headed</li><li>• Low BP or BP that drops or if dizzy when you going from lying to standing</li><li>• Poor skin turgor or skin that lacks elasticity</li><li>• Other signs that may indicate a problem:<br/>_____<br/>_____<br/>_____</li></ul> |
|--|--|

If noted:

Immediately Notify: Nurse \_\_\_\_\_ Supervisor \_\_\_\_\_ Other \_\_\_\_\_

Document on the Daily Notes \_\_\_\_\_ Other \_\_\_\_\_

Documentation reviewed by: \_\_\_\_\_ Frequency of Review \_\_\_\_\_

### Reasons for Dehydration Risk

Has a history of dehydration \_\_\_\_\_ Diabetes \_\_\_\_\_ Kidney disease \_\_\_\_\_

Has a history of Dysphagia \_\_\_\_\_

Has history of UTI's \_\_\_\_\_ Has history of constipation/impaction \_\_\_\_\_

Cannot communicate thirst \_\_\_\_\_ Functional limitations(cannot get own drink) \_\_\_\_\_

Is using medications known to cause dehydration such as diuretics or laxatives. \_\_\_\_\_

List all identified medications: \_\_\_\_\_  
\_\_\_\_\_

Other reasons/illnesses: \_\_\_\_\_  
\_\_\_\_\_

Name:

Completed by:

Date:

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Outreach Services of Indiana  
FSSA – State of Indiana

**What is Normal**

Typical daily intake \_\_\_\_\_ Typical daily urination pattern: \_\_\_\_\_

Is there a Schedule for Fluid Intake? Yes\_\_ No \_\_\_ If yes describe: \_\_\_\_\_

How communicates thirst: \_\_\_\_\_

Favorite drinks: \_\_\_\_\_

Special Instructions to assist with Fluid Intake: (Adaptive equipment, special/favorite cup, thickened fluids, time of day more likely to drink, use of a straw): \_\_\_\_\_

**Treatments and Prevention**

Recommended Fluid Intake: Yes\_\_\_ No\_\_\_ Describe: (Indicate total amount in cc's or ounces over what period of time): \_\_\_\_\_

Document on: Intake & Output Record\_\_\_ MAR/TAR\_\_\_ Other\_\_\_\_\_

What action is to be taken by staff if intake is less than recommended including who to notify and when to notify: \_\_\_\_\_

Documentation Reviewed by:\_\_\_\_\_ Frequency of Review\_\_\_\_\_

Record Last Void: Yes\_\_\_ No \_\_\_

Document on: Intake & Output Record\_\_\_ MAR/TAR\_\_\_ Other\_\_\_\_\_

What action is to be taken by staff if individual does urinate in \_\_\_ hours, including who to notify and when to notify: \_\_\_\_\_

Documentation Reviewed by:\_\_\_\_\_ Frequency of Review\_\_\_\_\_

Weigh: Daily\_\_\_ Weekly\_\_\_ Monthly\_\_\_ Other:\_\_\_\_\_

Record Weight on: Weight Record\_\_\_ MAR/TAR\_\_\_ Other: \_\_\_\_\_

If Weight gain or loss of \_\_\_ lbs. Notify: Nurse\_\_\_ Supervisor\_\_\_ Other:\_\_\_\_\_

Documentation Reviewed by:\_\_\_\_\_ Frequency of Review:\_\_\_\_\_

\*MAR-Medication Administration Record TAR-Treatment Administration Record

Client Name \_\_\_\_\_

Review Name/Dates \_\_\_\_\_

Outreach Services of Indiana  
Adapted from Oregon Fatal Four Protocol  
Date Revised: June 9, 2009

Name:

Completed by:

Date:

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